# Combat Stress Control Detachment: A Commander's Tool

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CONTROLLING COMBAT STRESS is the commander's responsibility and encompasses all the steps that the commander must take to keep an operations' strain on people within an acceptable range. Stress cannot be avoided, nor should it be, for the tension often generates productive energy. Commanders can seek to enhance those positive effects that create stress, such as esprit de corps, trust and heroism, while minimizing the negative effects, such as criminal acts, combat refusal and battle fatigue.

Battle fatigue—also referred to as combat stress fatigue, stress fatigue and combat reaction—is defined as any response to the stress of combat that requires treatment.[1] Signs and symptoms of battle fatigue may be present in many soldiers, but only when the soldier becomes combat ineffective is he considered to be a battle fatigue casualty and referred for treatment. Treatment, as the term fatigue would indicate, simply provides rest, reassurance, replenishment and restored confidence.[2]

This article will present the history of controlling combat stress and managing battle fatigue, describe the unique capabilities and role of the medical detachment, combat stress control (CSC), and through case examples, emphasize that combat stress control—trained, practiced and employed by the commander—is a combat multiplier.

## Historical Background

Historians have long described man's response to the extraordinary stress of war. We are motivated by heroic responses to combat pressures and, at the other extreme, horrified by atrocities. Commanders manage violence in more ways than by applying appropriate force at the decisive point. They must also manage their soldiers' ability to function in the uncommonly stressful environment of war—recognizing their fear but disciplining them not to run; preparing them to kill, but not indiscriminately.

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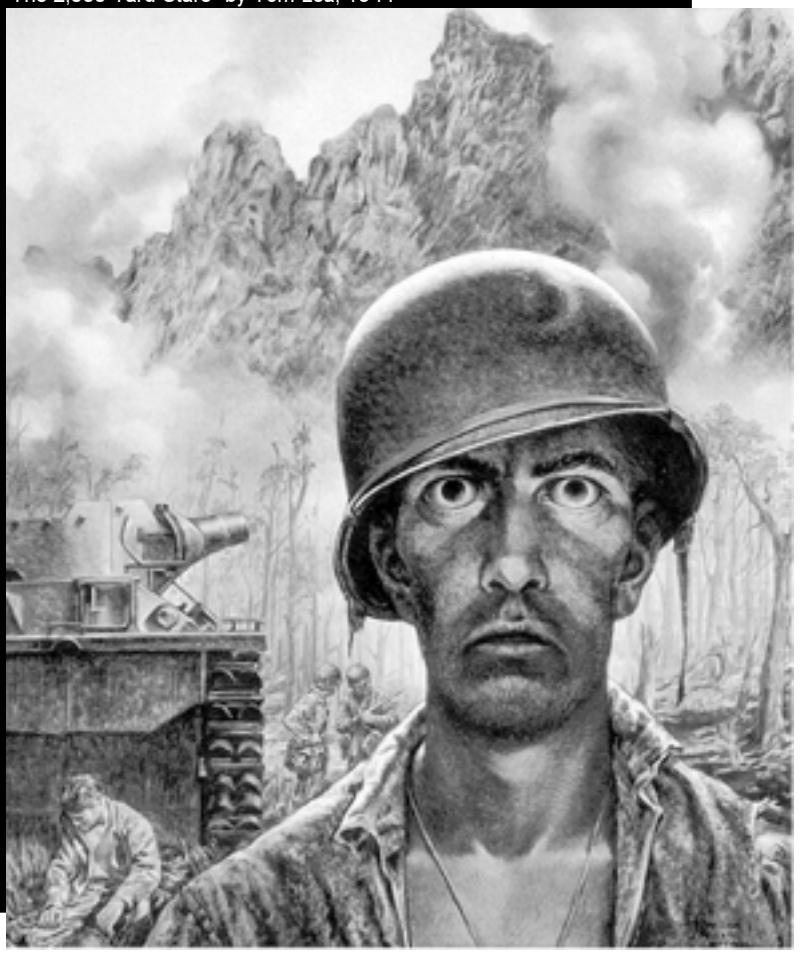
The evolution of 20th-century warfare has increased awareness of this balancing act. US Army physicians war in the American Civil War reported mass casualties from the stress of waging war when "nostalgia," a homesickness among troops, reduced fighting forces.[3] In World War I, "shell shock" as a condition and term was born in the trenches on the Western Front. At the time, treatment of shell shock or "war neurosis" consisted primarily of evacuation far from the front. However, this practice encouraged greater numbers of casualties. More important, these casualties did not improve with evacuation and were lost to combat.[4] By 1917, one seventh of all medically discharged British soldiers were unfit due to mental conditions.[5]

Prior to deploying combat troops to Europe, the US Army sent a medical team to study British and French lessons learned. Both the British and the French by then had established principles of

"The 2,000 Yard Stare" by Tom Lea, 1944



psychiatric casualty management that called for simple, immediate treatment as close to the front as possible, and both armies expected that soldiers would return to duty. From this experience developed the PIES acronym for treatment—proximity, immediacy, expectancy and simplicity. Another development from this study was the division psychiatrist position for implementing forward treatment principles, to include the recognition of battle fatigue by unit leaders and medical personnel.[6] Overall, a large percentage of World War I war neurosis cases were returned to duty.[7]

During the interwar years, rather than institutionalizing these World War I lessons about managing battlefatigue casualties, the Army looked to refine and apply early 20th-century theories of human behavior and development to screen out soldiers who would crack under the stress of battle. Relying on screening rather than training to prevent psychiatric casualties proved disastrous in early fighting in North Africa, when large numbers of battle fatigue casualties occurred among troops previously screened.[8] Worse, because no provisions had been made for treatment, casualties were shipped to distant treatment facilities and lost from the theater. In September 1943, the Army screened out more soldiers than it accepted, prompting a rapid rediscovery of World War I-style forward treatment principles. The effect was profound: returned to duty (RTD) rates increased from zero to 70 percent, and the concept of PIES was reestablished.[9]

Other developments soon followed. "Combat exhaustion" replaced war neurosis as the term describing battle fatigue. The division psychiatrist trained battalion surgeons to manage battle fatigue casualties and set up rest centers in the battalion trains. The regimental surgeon ran exhaustion centers, while the division psychiatrist established and oversaw training and rehabilitation centers. These centers firmly demarcated soldiers suffering combat exhaustion from those who were patients—whether surgical, medical or neuropsychiatric—de-emphasizing the patient status, restoring confidence and reassuring the soldier that he had experienced a normal response to abnormal stressors.[10]

In the intensive casualty studies following World War II, combat exhaustion received unprecedented scrutiny. Researchers found a higher incidence of battle fatigue casualties encountered among units in higher intensity combat and in units with prolonged exposure to combat, poor cohesion, ineffective leadership and higher rates of wounded or killed in action.[11] In Korea and Vietnam, stresses like defensive posture, lack of a clear enemy and substance abuse contributed to increased battle fatigue casu-

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alties.[12] By identifying precipitants, leaders could now train to offset them and prevent battle fatigue.

In the Korean War, lessons from World War II remained fresh, and forward treatment of battle fatigue casualty by battalion surgeons was the norm. Innovations such as buddy aid appeared. Psychiatric casualties accounted for only five percent of out-of-country evacuations.[13] The Korean War also saw the implementation of "KO" teams comprised of a psychiatrist, a social work specialist and a clinical psychologist.[14] The primary mission of these mobile teams was to augment a medical clearing company.

In Vietnam, KO teams found their role limited to augmenting fixed medical facilities.[15] This constraint, coupled with a poorly defined combat zone, troop rotations and theater evacuation policies obscured principles of combat psychiatry, namely, to maximize prevention and treat battle fatigue. By 1971, 61 percent of all medical evacuations from Vietnam were neuropsychiatric, indicating an abrogation of the principles of PIES. Recognizing this decline, the Army redesignated KO teams as OM teams in 1972 and through emphasis on mobility, refined their role to focus on preventive mental health care.[16]

During the Persian Gulf War, OM teams deployed to Southwest Asia and there engaged in a vigorous campaign to assess units' cohesion and perceived readiness for combat, train leaders and troops in controlling combat stress and provide feedback through all echelons of command—from company commanders to Army Central Command—on morale, readiness and controlling combat stress. During demobilization, the OM teams worked with chaplains and other mental health workers to prepare soldiers and their families for reunions.[17]

In 1992 the Army activated the medical detachment, CSC, as a successor to the OM team and as a corps-level adjunct to division mental health. The CSC mission is to provide comprehensive stress control support to a division or to two or three separate brigades or regiments through six primary functions of the CSC:

- *Consultation.* Liaison with and provide preventive advice to commanders and staff.
- *Reconstitution support.* Assistance to attrited units at field locations.
- *Combat neuropsychiatric triage.* Sorting battle fatigue casualties into categories based on how far forward they can be treated; also, determining which conditions are battle fatigue and which represent neuropsychiatric illness.
- *Stabilization.* Stabilizing severe battle fatigue casualty or neuropsychiatric cases and evaluating RTD potential or preparation for transport or evacuation.
- *Restoration.* Treating battle fatigue casualty with rest, water, food, hygiene and activities to revive their confidence in soldiering—80 to 85 percent of battle fatigue casualties are RTD within 1 to 3 days with restoration.
- *Reconditioning.* An intensive program lasting a week or more involving physical and military training and psychotherapeutic activities in a non-hospital setting.[18]

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## Organization of Mental Health Assets Available to the Commander

Presently there are six active component CSCs, six US Army Reserve (USAR) CSCs and no National Guard CSCs. The Reserves also have four CSC medical companies. The basis of allocation (BOA) of the CSC detachment is one per division; the BOA for the CSC company is one per two divisions. The CSC is comprised of 23 personnel.[19] The detachment headquarters and restoration section set up in the division support area, often collocated with the main support medical company or in some instances, a combat support hospital. The CSC prevention teams move forward to the brigade support area where they collocate with the forward support medical company.

Other mental health assets available to the commander are:

- *Division mental health service (DMHS).* A 10-member team headed by a psychiatrist assigned to the main support medical company in the division support command. This element is the primary resource for commanders within the division for

CSC. The DMHS has the further responsibility of providing comprehensive mental health care to the division.

- *Area support medical battalion (ASMB) mental health section*. A 10-member team headed by a psychiatrist (assigned through the professional filler system). This section provides stress control and mental health care throughout the ASMB's area of operations (AO).
- *Separate brigades' mental health section*. In light brigades one behavioral science noncommissioned officer (NCO) is assigned to the medical company; in heavy brigades, one mental health section, comprised of a behavioral science NCO and two behavioral science specialists is assigned. These personnel advise the commander on mental health and stress control issues.
- *Medical company, combat stress control*. Presently RC with BOA of one per two divisions. This unit is oriented towards controlling combat stress to the communications zone and combat zone. It may send teams forward to the division area to reinforce CSC detachment teams operating there.[20]


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## Employment of the Medical Detachment, Combat Stress Control

US Army Field Manual (FM) 8-51, *Combat Stress Control in a Theater of Operations*, and FM 22-51, *Leader's Manual for Combat Stress Control*, provide general descriptions of the use, employment and effectiveness of combat stress control. Each lays out a broad foundation of knowledge that leaders and planners can use to control combat stress. Real-world experience, however, is the best trainer. The following are four case examples of the CSC in operation. Each highlights the different capabilities of the CSC as described in FM 8-51 and in doing so, shows combat stress control as a combat multiplier.

**Operation *Arrowhead Scrimmage***. In March 1998 Prevention Team 1 from the 98th CSC deployed with the 3rd Brigade, 2d Infantry Division, to the Yakima Training Center (YTC), Yakima, Washington. Team 1 maintains an habitual relationship with the 3rd Brigade that included deployments to the National Training Center in May 1997, and YTC in January-March 1997.

While in garrison, the prevention teams from the 98th CSC train assigned units in controlling combat stress. Each of the detachment's three teams supports the major subordinate commands stationed at Fort Lewis, Washington; when those units go to the field, their assigned prevention teams go with them. This affords the 98th CSC valuable training while providing combat stress control to the affiliated unit.

During *Arrowhead Scrimmage* the 98th CSC prevention team treated five soldiers from the 3rd Brigade for symptoms of battle fatigue; four of these soldiers returned to duty within 72 hours. They would have otherwise been sent back to garrison and lost to training. Instead, their confidence restored, they completed training with their unit.

**Operation *Laredo Sands***. In February 1998 Prevention Team 2 from the 98th CSC deployed for two weeks to Laredo, Texas in support of the 864th Engineer Battalion (Combat, Heavy). The 864th En-

gineers had deployed in early January 1998 to build roads and buildings for Joint Task Force (JTF) *6*.

Beginning in October 1997, Team 2 and the leadership of the 864th Engineers developed a comprehensive combat stress control support plan that targeted areas of concern that the leadership and the CSC identified as potential hazards during the battalion's deployment.

The 98th CSC team trained each company in battle fatigue signs and symptoms, stress and anger management and conflict resolution. Team 2 briefed squad leaders and platoon leaders on the mission of the CSC and trained them in steps they could take to offset deployment stressors their soldiers faced. Team 2 also met with the 864th Engineer's family support group to address concerns related to the stress of deployment and redeployment faced by families.

In the Laredo AO, Team 2 conducted unit assessment interviews. These interviews were a consultative tool for the command and began with an interview of the battalion commander and his staff. Each company commander was then interviewed, and this process continued down the chain of command to the platoon and squad level. Through these interviews the CSC determined the command's view of the operation and morale of the troops. The team then interviewed groups of soldiers at their work sites throughout the 864th's area of operations and briefed the chain of command back up to the battalion commander on the findings of these interviews. This process served two important functions—it provided practical information to the command and the small-group interviews with the soldiers allowed them the opportunity to vent.

The prevention team provided mental health consultation to the battalion surgeon and reviewed sick call logs for trends (none were identified). No soldiers from the 864th Engineers required evacuation for mental health reasons during the two-month deployment.

**Operation *Joint Endeavor***. In December 1995 the 84th Medical Detachment, CSC from Fort Carson, Colorado, deployed to Bosnia as part of Task Force *Eagle* in Operation *Joint Endeavor*. There the 84th CSC coordinated its effort with the DMHS of the 1st Armored Division and together provided seamless combat stress control within the theater.[21]

Task Force *Eagle* remained in Bosnia for one year, the better part of which (from the soldier's perspective) was spent without a determined endpoint. The 27-member 84th CSC had 10,860 soldier contacts during its 352-day deployment. Significant among these numbers are 921 command consultations and 135 soldiers held for restorative care. Of the soldiers who used the 84th CSC's restoration services, 85 percent returned to duty after staying with the CSC for an average of six days.[22]

***In each, the CSC provided commanders with combat stress control, and through this, enhanced the unit's effectiveness. Weapons and soldiers are concrete, quantifiable and measurable means by which a commander can modify his combat power; controlling combat stress is neither quantifiable nor measurable, but can alter the course of the battle.***

The 84th CSC also debriefed survivors and observers of tragedies. The CSC responded on request of command and within 48 hours of the critical event. These debriefings reduced unit tensions and helped reduce soldier anxiety and dysfunction due to stress caused by the event. Moreover, through its efforts, the CSC gained credibility with the command.[23]

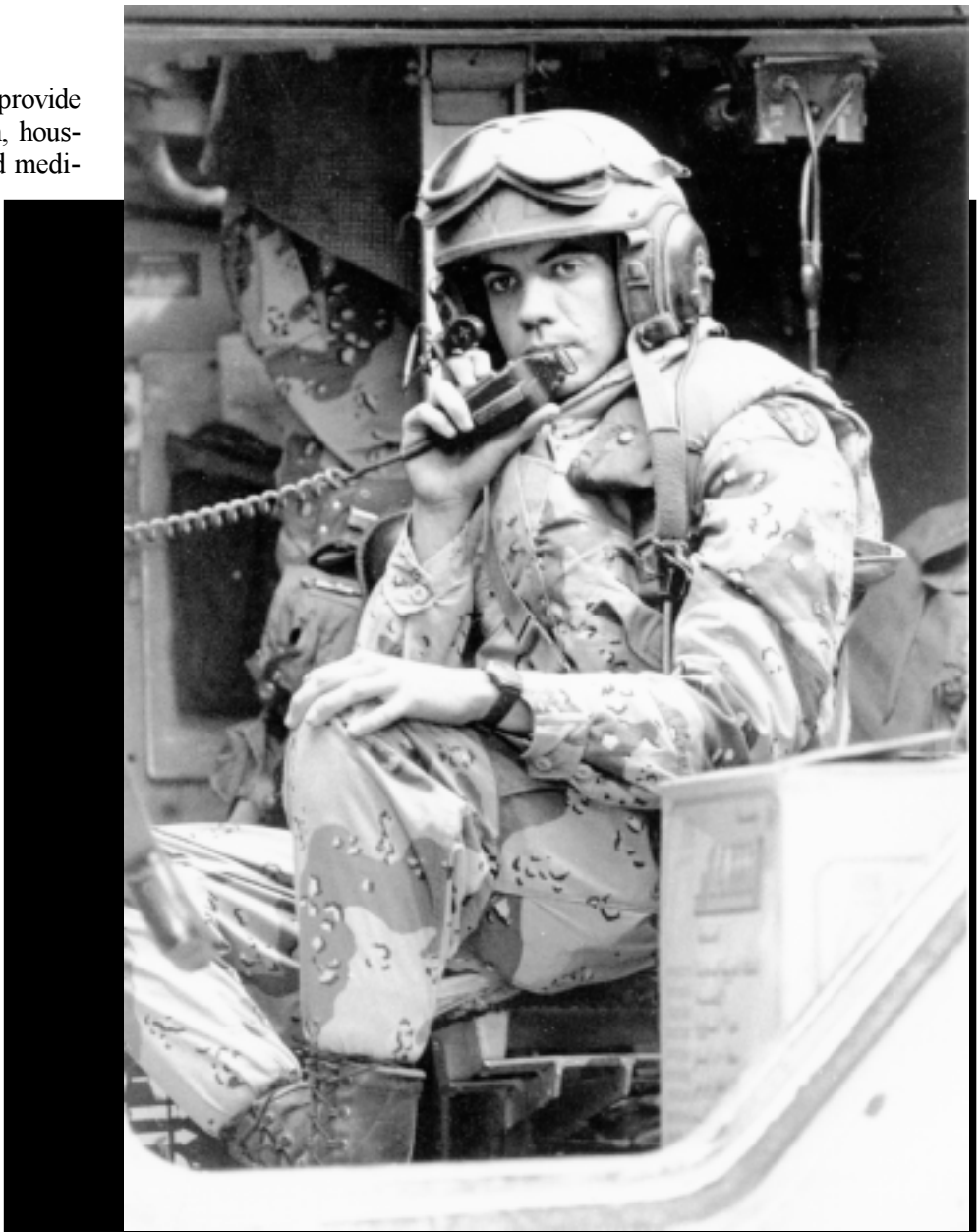
During the deployment, 15 task force soldiers attempted and one completed suicide, for an annualized rate far below the Army-wide rate of 14 suicides per 100,000 soldiers.[24] The 84th CSC provided suicide prevention (and other) classes in theater to leaders, chaplains and medical personnel and distributed cards and flyers to thousands of soldiers. The 84th CSC set up a 24-hour phone line to answer concerns from leaders about stressed soldiers.

Operation *Joint Endeavor* proved to be a success. Warring factions remained separated. Elections occurred. More important, although the US contingent represented one-third of the Implementation Force, US soldiers accounted for only 14 percent of those killed (or dead of natural causes) during the operation.[25] This success is rightly attributed to leadership and training. Leaders—from task force commander to squad leader—participated in CSC training, and in their attention to this detail enhanced the safety and effectiveness of soldiers.

**Operation *Sea Signal***. In June 1995 the 98th Medical Detachment, CSC(-), from Fort Lewis, deployed to Guantanamo Bay (GTMO), Cuba, to join

JTF *160*. The JTF mission was to provide humanitarian assistance, reception, housing and subsistence facilities, and medical care for migrants; support US Coast Guard interdiction and transport to GTMO operations; provide a safe and orderly environment for migrants, US personnel and property; coordinate with appropriate agencies and provide support for the screening, processing, paroling and movement of migrants; and take all possible measures to optimize the interim and long-term quality of life among migrants.[26]

The 98th CSC, in conjunction with the 83rd CSC, replaced the 85th CSC Detachment and the 616th CSC Company. The 98th CSC integrated into a joint medical task force whose mission was to provide direct care to over 20,000 Haitian and Cuban refugees. US Army personnel provided the bulk of the mental health professionals and leadership to the mental health treatment arm. In addition to providing outpatient mental health care to migrants, the 98th CSC cared for a cadre of dangerous psychiatric inpatients confined to a Navy brig.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The after-action report from the 98th CSC's deployment reported incidents of—

- Conflicts of interest between mental health professionals' roles as migrant care givers and evaluating clinician for the purpose of deportation; and
- Inequities in the component services' personnel rotation plans.[27]

No other CSC prevention efforts or interventions with US forces deployed to GTMO were reported.

These examples provide real-world demonstrations of CSC capabilities. Significant in all of these is that leaders thought to ask for this resource, planned its inclusion and then used it. Although the CSC may not have been critical to mission success or completion, its use in Yakima, Laredo, Bosnia and to a lesser extent, GTMO, enhanced the supported unit's capabilities and readiness.

During *Arrowhead Scrimmage*, the 98th CSC conducted a doctrinal restoration exercise. Consistent with historical data, 80 percent of soldiers referred to the CSC for treatment returned to duty. During *Laredo Sands*, the 98th CSC conducted consultation and exercised preventive measures. In both of these operations, the 98th worked through the leadership of the supported units, establishing credibility and providing CSC training for them. Further involvement early in the planning process optimized combat stress control and the use of the CSC.

Operation *Joint Endeavo*r is a singular success story in combat stress control. The command in-

volvement in training and implementing combat stress control required an in-depth understanding of the assets available (DMHS, CSC). This coordination led to the successful development of a theater mental health support plan consistent with FM 8-51 and RTD rates for battle fatigue that were consistent with historical expectations.

JTF *160* used the 98th CSC as mental health assets have been traditionally employed (consider the KO teams used to augment hospitals). This lack of appreciation for the CSC's capabilities diminished its effectiveness. However, this deployment occurred relatively early in the joint environment's understanding of the CSC detachment.[27] Moreover, while CSC doctrine developed with support of a US Army combat division in mind, JTF *160* combined Army, Air Force and Navy personnel in a noncombat, but nonetheless hostile and inhospitable, environment.

One could argue that the employment of the CSC was uninformed; however, a stronger argument can be made for their use being judicious, given the nature of the operation and the threat. Further, through its direct mental health care for the migrant population, the CSC provided some relief to the US forces assigned to protect and guard these refugees. Additionally, it consulted with leaders on the effectiveness of refugee management, directly supporting the JTF mission of optimizing quality of life.

In none of these case examples did the CSC operate in the environment or fashion for which it was ostensibly designed. Yet in each, the CSC helped commanders control combat stress, and through this, enhanced the unit's effectiveness. Weapons and soldiers are concrete, quantifiable and measurable means by which a commander can modify his combat power; combat stress control is neither quantifiable nor measurable, but can alter the course of the battle. Modern commanders, faced with intense, continuous combat, or with low-intensity, ambiguously contained peacekeeping missions have the CSC medical detachment as a tool to optimize their units' performance. *MR*

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## NOTES

1. US Army Field Manual (FM) 8-51, *Combat Stress Control in a Theater of Operations* (Washington, DC: US Government Printing Office [GPO], September 1994), 1-6.
2. Ibid.
3. COL Franklin D. Jones, M.D., (Retired), "Psychiatric Lessons of War," *Textbook of Military Medicine: War Psychiatry* (Office of the Surgeon General, United States Army, 1995), 8.
4. Ibid.
5. Ibid., 9.
6. FM 8-51, 1-10.
7. Ibid.
8. Jones, *Textbook of Military Medicine: War Psychiatry*, 12.
9. Ibid.
10. FM 8-51, 1-10.
11. Jones, *Textbook of Military Medicine: War Psychiatry*, 13-16.
12. Ibid., 16-20.
13. Ibid., 16.
14. FM 8-51, 1-10 and 11.
15. Ibid., 1-11.
16. Ibid.
17. Ibid.
18. Ibid, 2-1-2-10.
19. Under Medical Force 2000 (MF2K) the CSC expands to 24 personnel. Further expansion to 43 personnel occurs in TAA5, under the Medical Reengineering Initiative (MRI) which blends the Active Component with Reserve Component in units by FY2002.
20. MAJ Simon Pincus and MAJ Dave Benedek, "Operational Stress Control in the Former Yugoslavia; A Joint Endeavor," presented at the AMEDD Behavioral Science Short Course, Tampa, Florida, 27 April through 2 May 1997.
21. Ibid.
22. Ibid.
23. Ibid.
24. Ibid.
25. MAJ Simon H. Pincus and LTC Theodore S. Nam, "Psychological Aspects of Deployment: The Bosnian Experience", presented at the American Psychiatric Association Annual Meeting, San Diego, California, 17-22 May 1997.
26. 98th Medical Detachment (CSC) After-Action Review, Operation *Sea Signal*, November 1995.
27. E.C. Ritchie, D.C. Ruck and M.W. Anderson, "The 528th Combat Stress Control Unit in Somalia in Support of Operation Restore Hope," Military Medicine, 1994, 159 and 372-376. Similarily, the 528th Medical Detachment, CSC activated on 16 December 1992 and deployed on 6 January 1993 in support of Operation *Restore Hope*, encountered ambiguity over its role.

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